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No. 97-53

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In The

Supreme Court of the United States

October Term, 1998

JANE M. ROBERTS, Guardian for Wanda Y. Johnson,

Petitioner,

vs.

GALEN OF VIRGINIA, INC., Formerly d/b/a Humana Hospital – University of Louisville,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

REPLY BRIEF OF PETITIONER

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INTRODUCTION

After five years of litigation and the consumption of untold judicial resources, the Respondent disavows the single rationale invoked by the lower courts in dismissing Petitioner's case and abandons the position it championed throughout these proceedings in a style analogous to its abandonment and disavowal of the Petitioner herself which gave rise to this suit.

The Respondent concedes the only issue upon which the Court granted certiorari. Therefore, this matter is ripe for reversal and remand for trial on the merits of the Petitioner's claims. Undeterred, the Respondent implores the Court to entertain additional grounds for affirming the lower court's summary judgment and it urges the Court not to embrace the interpretation of the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd ("EMTALA"), proposed by the United States in its amicus brief for fear of "extraordinary" interference by the federal government with the practice of medicine in the hospital setting.[1]

While it is impossible to adequately address the merits of the Respondent's alternative grounds for affirmance and also respond to its articulated fear of the "federalization" of medical malpractice law within the page limitations of a Reply Brief, the Petitioner will point out why those alternative grounds are inappropriate for

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[1] The Respondent fails to acknowledge that its own decision to tap public funds by electing to participate in the Medicare program and to accept millions of additional public dollars from state and local governments justifies accountability to the public and those governmental agencies.

this Court's consideration. Furthermore, the Petitioner will address the Respondent's unwarranted concerns about the interpretation of EMTALA proposed by the United States.

ARGUMENT

I. THE COURT SHOULD NOT CONSIDER THE ALTERNATIVE GROUNDS FOR AFFIRMANCE URGED BY THE RESPONDENT BECAUSE NEITHER WAS PROPERLY PRESERVED FOR REVIEW.

After acknowledging that the lower courts erred in the sole rationale utilized to dismiss Petitioner's claim by summary judgment, the Respondent proposes that summary judgment nonetheless be affirmed because (a) it had no duty to stabilize Wanda Johnson since her treating physicians did not have actual knowledge that she was suffering from an emergency medical condition at the time they ordered her discharge and, (b) EMTALA does not apply to treatment and transfer decisions made after a patient's initial emergency room screening and stabilizing treatment and admission into the hospital. These alternative arguments go to the threshold issue of the applicability of EMTALA, not the issue considered by the Sixth Circuit in this case, i.e., the appropriate standard of proof of EMTALA violations where applicability has been established. Although the Respondent claims otherwise,

it is clear that neither of these issues is ripe for consideration by this Court.[2]

The Respondent devoted approximately one page of its 26-page initial memorandum in the trial court to an argument that it was entitled to dismissal because EMTALA was inapplicable to Wanda Johnson's transfer where her treating physicians did not perceive that she suffered from an emergency medical condition at that time. The trial court, although not expressly considering this argument, overruled the Respondent's motion for partial summary judgment. The Respondent then abandoned this argument, not citing this ground for dismissal in either the motion for reconsideration to the trial court which resulted in the entry of summary judgment or at any time before the Court of Appeals for the Sixth Circuit. The Respondent now claims that it made reference to this long abandoned argument in its Sixth Circuit brief. However, the passage quoted from that brief was not part

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[2] The Respondent's grounds for proposing that the Court extend jurisdiction and decide its two new issues is truly unique. It acknowledges that neither was "addressed" below but contends that "it is plain that, if the Sixth Circuit had rejected either of the alternative theories, then such a decision would warrant review by this Court for essentially the same reason this case was appropriate for review – a split in the circuit courts of appeals on a recurring legal issue of federal law." (Respondent's Brief at 33). However, it is not at all "plain" that a rejection by the Sixth Circuit of these arguments would have created a split among the circuit courts of appeals. Furthermore, where, as here, the issues have not been fully briefed or argued below, the "interest in efficient judicial administration" would not be furthered by entertainment of these alternative grounds.

of an argument that Johnson's treating physicians were unaware of an *emergency medical condition* on the date of Johnson's transfer, but, instead, was part of the Respondent's attempt to explain the holding in *Vickers v. Nash General Hosp, Inc.*, 78 F.3d 139 (4th Cir. 1996), and the Respondent's contention that Johnson's treating physicians were unaware that Johnson's condition was *not stable* upon transfer.

This claim for dismissal, briefly mentioned in the trial court and then abandoned, was undoubtedly rejected when the lower court initially overruled the Respondent's motion for summary judgment because it ignores the distinction between the separate duties imposed by EMTALA upon hospitals to provide an appropriate medical screening *and* to stabilize patients who present with an emergency medical condition. The Respondent concedes that Johnson arrived at its hospital emergency room with an emergency medical condition. The existence of Johnson's emergency medical condition, as revealed by the Respondent's medical screening examination, triggered the hospital's second duty under EMTALA – to provide stabilizing treatment and to refrain from transferring her elsewhere unless her condition was stabilized at the time of transfer. *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990).

The Respondent apparently contends that in addition to its initial medical screening examination which revealed an emergency medical condition, it conducted subsequent medical screening examinations, including a medical screening examination on the day of Johnson's transfer. Presumably, that final medical screening examination revealed no emergency medical condition. The fallacy of Respondent's argument lies in the notion that

hospitals can conduct *multiple* screening examinations and that the outcome of each examination then determines its concomitant duty to the patient under EMTALA. EMTALA clearly contemplates that a single medical screening examination take place at a hospital's emergency room upon the patient's initial presentation to the facility. 42 U.S.C. § 1395dd(a). The statute provides that if this initial medical screening examination does not reveal an emergency medical condition, no further EMTALA duties are triggered. Where, as in Johnson's case, the hospital conducted its initial medical screening examination and determined that an emergency medical condition existed, its duty under EMTALA is to provide stabilizing treatment and to ensure that the patient is still in a stabilized condition prior to any transfer. The Respondent cannot successfully argue here that it "screened" Johnson each day and determined, although incorrectly, that no emergency medical condition existed at the final such "screening." In fact, there is ***no evidence*** that such a "pre-transfer" screening was actually performed in this case.

The cases cited by the Respondent are easily distinguishable. None deal with the situation that is present in this case, i.e., where the hospital's initial medical screening examination actually revealed an emergency medical condition. In each of the cases cited by the Respondent, the hospital's medical screening examination in the emergency room failed to reveal an emergency medical condition and therefore did not trigger the additional stabilization duties imposed by EMTALA.[3]

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[3] See *Marshall v. East Carroll Parish Hosp.*, 134 F.3d 319 (5th Cir. 1998) (Hospital physician failed to diagnose cerebro-

Even if the Respondent's interpretation of EMTALA were correct, it would not be entitled to summary judgment. The Respondent cites the affidavits of its doctors for the proposition that those doctors perceived no emergency medical condition on the date of Johnson's transfer. However, the cited affidavits do not address the specific

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vascular accident, believed patient had only respiratory infection and discharged her from emergency room); *Vickers v. Nash Gen. Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996) (Hospital emergency room failed to diagnose skull fracture and discharged patient who died four days later); *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132 (8th Cir. 1996) (Hospital believed patient was suffering from muscle spasms, not emergency medical condition, upon presentation to hospital emergency room, was not admitted to the hospital and discharged with instructions to see a doctor the next day); *Eberhardt v. City of Los Angeles*, 62 F.3d 1253 (9th Cir. 1995) (Emergency room doctors diagnosed heroin overdose and permitted patient to walk out of hospital. Patient was shot by police 30 hours later in a crazed state); *Urban by and through Urban v. King*, 43 F.3d 523 (10th Cir. 1994) (Hospital emergency room staff failed to diagnose fetal stress and instructed patient to return for repeat stress test the following morning); *Holcomb v. Monahan*, 30 F.3d 116 (11th Cir. 1994) (Plaintiff failed to provide evidence that patient had emergency medical condition when discharged from emergency room); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991) (Patient discharged from emergency room after doctors diagnosed musculoskeletal pain. The next morning, the patient died of a heart attack); *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990) (Patient discharged four hours after his arrival to the emergency room diagnosed with influenza. The patient died later that same day after experiencing cardiopulminary arrest).

issue of whether Johnson had an emergency medical condition prior to her transfer. Rather, those affidavits contend that Johnson's emergency medical condition had been stabilized.[4] Dr. Frank Miller was the only physician who specifically addressed the issue of whether Johnson had an emergency medical condition on the date of her transfer. However, Dr. Miller admitted that he was on vacation at the time Johnson was transferred and neither examined Johnson nor was even at the hospital on or near that date. (Deposition of Frank Miller, M.D., R. 53, at 9-10). His opinion was based entirely upon a review of Johnson's medical records.

Dr. John Stuy, Johnson's treating physician in Indianapolis, also reviewed Johnson's medical records for the last days of her hospitalization at the Respondent's hospital. His deposition testimony can easily be read to express an opinion, contrary to that of Dr. Miller's, that on the date of her transfer Johnson had an emergency medical condition which any reasonably competent practitioner would have recognized. (J.A. at 62-70). This opinion is buttressed by the deposition testimony of hospital employees[5] who explained that on the evening before her discharge, Johnson's right lung had collapsed, and that

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[4] The statutory definitions of "emergency medical condition", "stabilized" and "to stabilize" have very different definitions. *Compare* 42 U.S.C. § 1395dd(e)(1) with 42 U.S.C. § 1395dd(e)(3)(A) and 42 U.S.C. § 1395dd(e)(3)(B).

[5] 42 U.S.C. § 1395dd(b) imposes stabilization duties and transfer restrictions when a "hospital" determines that the individual has an emergency medical condition. The Respondent's argument incorrectly imposes those duties only when a "physician" makes such a determination.

on the morning of her transfer, Johnson's white blood count was over twice the normal level, her temperature had been rising for two days and the presence of infection was indicated by her cloudy urine, thick yellow sputum and an elevated heart rate. (Deposition of Donna Kaelin, R. 48 at 16; Deposition of Karen Martin, R. 9 at 14-19; Deposition of Suzanne Griffith, R. 49 at 9-10). Construing the evidence and all reasonable inferences in the light most favorable to the Petitioner, Respondent clearly is not entitled to summary judgment on this surprise new ground.

The Respondent's second alternative argument for affirmance is even less appropriate for serious consideration. Respondent admits to having an EMTALA-imposed duty to stabilize patients like Johnson, but asserts that such duty only applies in emergency room settings and ceases after the patients are admitted to the hospital.[6] In short, it contends that EMTALA applies only to emergency rooms. Respondent's contention to the

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[6] In making this argument, the Respondent takes unwarranted liberty with its characterization of the Petitioner's contention in this case. Respondent's assertion that the Petitioner "has never disputed that Mrs. Johnson's initial injuries were stabilized during her two-month hospital stay," is simply not true. It has been the Petitioner's claim that Wanda Johnson's condition was volatile during her entire hospitalization. The urinary tract infection, collapsed lung, signs of pneumonia and elevated temperature experienced by Johnson during the final days of her hospitalization in Louisville were not "new" conditions never before experienced by Johnson. Rather, they were recurrent problems associated with Johnson's emergency medical condition which the Respondent had been unable to "stabilize."

contrary, this argument was *never* asserted in the courts below. The snippets quoted by the Respondent from its lower court briefs to the effect that "EMTALA applies first and foremost to a patient who comes to a hospital seeking treatment for an emergency medical condition" is far short of this entirely new and novel argument that a hospital's obligations cease once a patient moves from the emergency room to a hospital room.

In fact, the Respondent's new argument is directly at odds with the precedent established by the Court of Appeals for the Sixth Circuit in *Thornton* where the court rejected the notion that a hospital's stabilization duties under EMTALA were extinguished when the patient was transferred from a hospital emergency room to the hospital's intensive care unit for ten days and then to the hospital's regular in-patient care for eleven days before being discharged. The court explained:

> [a]lthough emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. . . . Emergency care must be given until the patient's emergency medical condition is stabilized.

895 F.2d at 1135.

The courts below expressed no views on the issues now raised by the Respondent and neither issue was argued or resolved. In fact, the lower courts had moved beyond the threshold applicability arguments now presented by the Respondent to consider the standard of proof for EMTALA violations where the Act had been determined to be applicable to Wanda Johnson's case.

Finally, the Respondent failed to identify either of these issues as bearing upon the matter before the Court if certiorari was granted in its brief in opposition to the petition for writ of certiorari as required by Sup. Ct. R. 15.2. Scarce judicial resources have been committed to deciding the merits of the question presented in the petition and new and novel issues presented at this time by the Respondent should be deemed by the Court to have been waived.[7]

II. THE INTERPRETATION OF EMTALA PROPOSED BY THE UNITED STATES DOES NOT CREATE A FEDERAL STANDARD OF CARE FOR MEDICAL DIAGNOSIS AND TREATMENT FOR PATIENTS WHO ENTER HOSPITAL EMERGENCY ROOMS AND SHOULD BE ADOPTED.

As pointed out by the Respondent, this is the first case the Court has agreed to review arising under

[7] To permit the Respondent to now introduce supplemental issues for consideration would both deprive the lower courts of the benefit of first considering those issues and deny the parties the opportunity to properly prepare a record thereon. In addition, it would frustrate the amicus curiae process. By granting a writ of certiorari on a specific issue, potential interested parties have notice and an opportunity to provide the Court with helpful perspectives to assist in the decision-making process. It is apparent from the number of groups who have participated as amici in this case that interpretation of EMTALA has important implications to many people and organizations in this country. If the Respondent is permitted to change the issue, the Court will not have the benefit of the perspectives of these interested persons and groups on these issues first raised by Respondent after submission of the amici briefs.

EMTALA. Though the Respondent concedes that, contrary to the Sixth Circuit's holding, the nature of proof required of a claimant to establish a violation under EMTALA has nothing to do with the motivations of hospitals, staff and physicians, the related and "fairly included" question of the *appropriate* standard of proof remains at issue. Both the Respondent and the United States urge the Court to define the standard of proof required of a claimant where EMTALA is applicable. The Petitioner urges the Court to adopt the position espoused by the United States because it is wholly consistent with EMTALA's purpose – namely, to deter patient dumping and to compensate victims of dumping. Nothing in EMTALA threatens to "federalize" medical malpractice law as claimed by the Respondent.

In defining the appropriate standard of proof under EMTALA we must begin one step beyond the question of the Act's applicability and Respondent's overheated rhetoric that the government's reading would transform EMTALA into a "litigation-creating machine."[8] Assuming a case, such as the one before the Court, where the claimant has established that EMTALA applies, the inquiry becomes the nature of proof required to show a violation.

EMTALA seeks to insure that all Americans not only have *access* to emergency treatment at Medicare participating hospitals, but also receive therefrom such treatment as is necessary to stabilize their condition at least at

[8] Indeed, the lower courts determined that EMTALA was applicable to this case but determined that the Petitioner had failed to establish violation of the Act under their heightened and erroneous "improper motive" standard.

the minimum level of quality required by the medical profession's own established norms. Hospitals are required to provide stabilizing treatment based upon objective "reasonableness" standards. In other words, a hospital's "negligent" violation of EMTALA is actionable. EMTALA's key definitions focus on the reasonableness of a hospital's determinations of medical probabilities and medical benefits under the circumstances prevailing at the time of treatment. If a hospital makes a determination that a patient has been stabilized, the hospital is liable only if it made the determination unreasonably, i.e., negligently. Of course, these standards are familiar to the Respondent and to other hospitals because they are the same standards used under state tort law.

Contrary to the Respondent's claim, this reasonableness or negligence standard neither preempts state medical malpractice laws nor establishes a federal standard of emergency care. In fact, Congress explicitly disclaimed any intent to preempt state law or to "occupy the field" of medical malpractice law. Instead, EMTALA provides that, "the provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with the requirements of this section." 42 U.S.C. § 1395dd(f).

Far from field preemption, Congress merely intended in EMTALA to provide for conflict preemption. Nothing in EMTALA prevents states from simultaneously regulating the same conduct by state medical malpractice or other laws.[9] It is well established that conflict preemption

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[9] As pointed out by Petitioner's amici, no fewer than twenty-two states had already passed laws governing the provision of emergency services when EMTALA was enacted. (Brief of Amici Curiae, NOW Legal Defense and Education Fund and others, in support of Petitioner, at 11 n. 5).

does not forbid double regulation, it only preempts those state laws where compliance with both federal and state regulations is a physical impossibility or which pose "as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." See, e.g., *California Federal Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272 (1987) (discussing the preemptive effect of Title VII). Under this preemption standard, it is apparent that existing medical malpractice laws are preserved and that state laws which punish the same conduct as EMTALA, whether malpractice torts or otherwise, are perfectly appropriate.

As urged by the United States, rather than establishing a federal standard of emergency room care, EMTALA simply borrows well-developed state-law standards of medical reasonableness to assess conduct. This interpretation is consistent with this Court's prior holdings that even though the scope of a federal right is a federal question, its content may be determined by state, rather than federal law, particularly where there is no federal body of law and the courts can draw on the ready-made body of state law addressed to the subject. See *United States v. Kimbell Foods, Inc.*, 440 U.S. 715 (1979) (incorporating state law to determine priority between state and federal liens); *De Sylva v. Ballentine*, 351 U.S. 570 (1956) (deciding that state law determines whether a child is a "child" for the purpose of taking statutory copyright renewal rights, to avoid upsetting settled expectations under state intestacy and family laws);

Reconstruction Finance Corp. v. Beaver County, Pa., 328 U.S. 204 (1946) (upholding a state tax applied to Reconstruction Finance Corporation property). Indeed, this reading is fortified by Section (d)(3)(A) of EMTALA which provides that personal injury damages against a hospital under the Act are assessed "under the law of the State in which the hospital is located." 42 U.S.C. § 1395dd(d)(3)(A). This reading therefore does not violate principles of federalism. On the other hand, if the Respondent is correct that EMTALA is simply a "gap-filler" and serves only the purpose of creating a duty to enter into a physician-patient relationship in the hospital setting and then gives way to state medical malpractice laws, Congress would have stopped after enacting the medical screening requirements of 42 U.S.C. § 1395dd(a).[10] At the point when the medical screening examination is provided, a physician-patient relationship has been formed and state medical malpractice laws are triggered. Instead, after Congress accomplished the objective of forcing a physician-patient relationship it proceeded to address the manner in which Medicare

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[10] If the Respondent's reading is correct, it stands to escape liability under both state and federal law. The Sixth Circuit determined that the independent contractor surgical resident from the University of Louisville Medical School who authorized Wanda Johnson's discharge was not the ostensible agent of the Respondent's hospital and that therefore, the Respondent was not liable under state medical malpractice law if the surgical resident's discharge decision was negligent. J.A. at A16-A23. In light of this ruling, the Respondent can be accountable to Wanda Johnson for the surgical resident's negligence only under EMTALA because it imposes direct rather than vicarious liability upon hospitals.

hospitals are required to treat their patients in 42 U.S.C. § 1395dd(b) and (c).

Perhaps the clearest expression of Congress's intent that hospitals' conduct be governed by existing standards of medical reasonableness was its 1990 OBRA amendments providing that, "[i]n considering allegations of violations of [EMTALA] and imposing [civil penalties]", the secretary shall "request the appropriate utilization and quality control peer review organization [PRO] . . . to assess whether the individual involved had an emergency medical condition which had not been stabilized." OBRA 1990, § 4027(a)(1)(A), 104 Stat. 1399-117, codified at 42 U.S.C. § 1395dd(d)(3). As pointed out by the United States, Congress's decision to require use of the PRO mechanism in civil penalty actions under EMTALA fully supports the conclusion that Congress understood that EMTALA liability is premised on adherence to recognized medical standards of care.

Although the Respondent urges the Court to reject the standard of proof proposed by the United States, it offers no alternative standard for consideration. Instead, it pleads with the Court to reach a decision, any decision, that would limit EMTALA's scope and applicability and make it more difficult for claimants to prove violations. It would have this Court believe that the United States seeks to federalize medical malpractice law in the hospital setting and to inject itself into the medical decision making process throughout the country. This is simply not the argument pressed by the United States and the Respondent's attempts to mischaracterize that argument should be rejected. Instead, the Court should adopt the position of the United States that Congress intended to

hold hospitals accountable for their negligent violation of EMTALA.

CONCLUSION

The judgment of the Court of Appeals for the Sixth Circuit should be reversed. This case should be remanded to the United States District Court for the Western District of Kentucky for a trial on the merits of the Petitioner's claim that the Respondent violated EMTALA.

Respectfully submitted on
October 20, 1998,

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